FY 2010 and FY 2011 NS Application for Funding
Sickle Cell Trait Follow-up Services

ISDH Maternal and Children's Special Health Care Services Division (MCSHC) makes funds available for specific programs using this Grant Application Procedure (GAP). This GAP has been specifically designed for the Sickle Cell program.

This Grant Application Procedure is integrated with the mission of the Indiana State Department of Health (ISDH): "The Indiana State Department of Health supports Indiana's economic prosperity and quality of life by promoting, protecting and providing for the health of Hoosiers in their communities."

ISDH has also developed the following priority health initiatives:

1. Data-driven efforts for both health conditions and health systems initiatives
    - Effective, efficient, and timely data collection.
    - Evidence-based and results-oriented interventions based on best practices.
2. INShape Indiana
    - Promotion of prevention and individual responsibility especially in the areas of obesity prevention through good nutrition and exercise and smoking cessation.
    - Participate in this effort with all components of communities – collaborative partners.
    - Integrate INShape opportunities in all programming and communications.
3. Integration of medical care with public health
    - Appropriately targeted access to care for underserved Hoosiers.
    - Opportunities for Medicaid demonstration projects to showcase successful public health-based interventions.
    - All direct and enabling services providers must be Medicaid providers
4. Preparedness
    - Continual scanning for developing public health threats regardless of cause of the threat (particularly direct medical care projects).
    - Planning and training for poised and effective response to threats that cannot be prevented.
    - Coordinate with the Local Public Health Coordinator.

Instructions

1. An application for Newborn Screening (NS) funds must be received by ISDH MCSHC by April 10, 2009.
2. Mail application to: Indiana State Department of Health
   ATTENTION: Randy Gardner, Asst. Grants Coordinator
   2 North Meridian Street, Section 8C
   Indianapolis, IN 46204
3. Submit the original proposal and three copies. Do not bind or staple.
4. The application must be typed (no smaller than 12 pitch, printed on one side only) and double-spaced. Each page must be numbered sequentially beginning with Form A, the Applicant Information page.
5. The narrative sections of the application must not exceed 30 double-spaced, typed pages. Applications exceeding this limit will not be reviewed.
6. Appendices, excluding CV's, must not exceed 20 pages. Appendices that serve only to extend the narrative portion of the application will not be accepted.
7. The application must follow the format and order presented in this guidance. Applications that do not follow this format and order will not be reviewed.
8. The application will not be reviewed if all sections are not submitted.

Note: Questions about this application should be directed to Bob Bowman, Director of Genomics and Newborn Screening, at 317.233.1231 or BobBowman@isdh.IN.gov.

CRITERIA FOR ELIGIBILITY

Prerequisites

Applicants must be a facility with the capability of performing Sickle Cell services to at least one of the designated regions.* Applicants can apply to provide services to more than one region, provided that the applicant has a facility located in each region included in the applicant's proposal.

Purpose of Grant

Provide early intervention through direct/consultative follow-up services for children born in Indiana and for children originally referred by the Indiana University Newborn Screening (NBS) Laboratory for having a newborn screening result that is presumptive positive for the Sickle Cell trait or a trait of another hemoglobinopathy.

NOTE: Documentation of services administered must be provided upon request by the Indiana State Department of Health (ISDH).

Description of Required Services

Applicants must be able to provide the following services:

1) Intervention services for all children born in Indiana and originally referred by the NBS Laboratory for a presumptive positive or confirmed diagnosis of Sickle Cell trait or trait of another hemoglobinopathy. Required activities to include but not limited to the following:
    a. Contacting the primary care providers (PCPs) and/or families of children with NBS results that are presumptive positive for the Sickle Cell trait or for trait of another hemoglobinopathy by 4 weeks of age.
    b. Disseminating the ISDH Sickle Cell Trait Educational Packet (e.g. information on Sickle Cell trait, brochures, applications/information on family resources) to PCPs and families of children with a hemoglobinopathy trait.
    c. Referring families of newborns with Sickle Cell trait or trait of another hemoglobinopathy to appropriate resources (e.g. genetic counseling, Women with Infants and Children (WIC), family support resources).
    d. Providing families with assistance when applying to appropriate resources and/or programs.
    e. Ensuring that appropriate confirmatory testing is performed (if necessary).
2) Provide educational, counseling, and follow-up services to families of children with Sickle Cell trait or trait of another hemoglobinopathy. Required activities to include but not limited to the following:
    a. Disseminating appropriate educational materials (e.g. information on Sickle Cell disease, brochures, applications/information on family resources) to PCPs and/or families of children with a hemoglobinopathy trait.
    b. Referring families of newborns with Sickle Cell trait or trait of another hemoglobinopathy to appropriate resources (e.g. genetic counseling, Women with Infants and Children (WIC), family support resources).
    c. Providing families with assistance when applying to appropriate resources.
    d. Ensuring that appropriate confirmatory testing is performed (if necessary).
3) Increase awareness regarding health behaviors that impact the patient population and birth outcomes. Required activities to include but not limited to the following:
        a. Providing education regarding the negative effects of using tobacco, alcohol, or other drugs and the positive effects of taking folic acid.
        b. Ensuring that patients who admit to smoking, drinking alcohol, or using drugs are referred to appropriate community resources.
4) Provide educational presentations to the general public.
5) Participate in the Community Integrated Service Systems (CISS) advisory committee and any initiatives put forth by this committee.

Size of Population Being Served

The grantee will be expected to provide educational/referral services for all children born in the selected region(s), along with their families and health care providers throughout the state of Indiana.

Annually, there are approximately 1,000 children born in Indiana who have NBS results that are presumptive positive for sickle cell trait.

- Approximately 58% are born within the Central/Southern region of the state.
- Approximately 26% of the remaining infants are born within the Northwest region.
- Approximately 16% are born within the Northeast region of the state.

Reporting Requirements

1) The grantee shall be expected to maintain a log of follow-up services provided for *all* children who receive services funded by this grant. This log shall be maintained for direct (face-to-face) or indirect (telephone) consultations to include but not limited to:
    a. Child's name
    b. Child's DOB,
    c. Parent's name and address,
    d. PCP's name and address,
    e. Date and time of phone conversations,
    f. Summary of phone conversation,
    g. Date packets were mailed,
    h. Name and address that packets were mailed to,
    i. List of any additional information included in the packet.
    j. Method of consultation,
    k. Date and time of consultation,
    l. Summary of consultation,
    m. List of information provided to the parents.
    n. Received completed evaluation
2) The grantee shall be required to participate in quarterly meetings with the ISDH Director of Genomics and Newborn Screening and the Sickle Cell Program Director in order to clarify and resolve the status of any open cases.
3) The grantee shall be expected to utilize the ISDH Newborn Screening web application, when available, in order to maintain complete records and track all children receiving services funded by this grant.
4) The grantee shall be prepared to provide documentation for auditing purposes as needed to ensure compliance with requirements outlined in the grant proposal.

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*Three (3) separate regions throughout the state have been created. The counties associated with each region are:

Northwest IN	Northeast IN	Central/Southern IN
Benton	Adams	All other counties
Carroll	Allen	
Cass	DeKalb	
Jasper	Elkhart	
LaPorte	Fulton	
Lake	Grant	
Newton	Huntington	
Porter	Kosciusko	
Pulaski	LaGrange	
Starke	Marshall	
White	Miami	
	Noble	
	St. Joseph	
	Steuben	
	Wabash	
	Wells	
	Whitley	

FORMS

Applicant Information (Form A)

NS Project Description (Forms B-1 and B-2) *NOTE: B-1 does not substitute for a project summary.*

Funding Currently Received by Your Agency from ISDH (Form C)

APPENDICES

Appendix A – Sickle Cell Trait Follow-up Services Providers Annual Performance Report

Appendix B – Definitions (NS Services)

Appendix C – Grant Application Scoring Tool

Priority Health Needs for the MCSHC population, 2006 – 2011

1. To decrease high-risk pregnancies, fetal death, low birth weight, infant mortality, and racial and ethnic disparities in pregnancy outcomes. (ISDH Priorities #1 & #3)

2. To reduce barriers to access to health care, mental health care and dental care for pregnant women, infants, children, children with special health care needs, adolescents, women and families. (ISDH Priorities #1, #3, & #4)

3. To build and strengthen systems of family support, education and involvement to empower families to improve health behaviors. (ISDH Priorities #1, #2, & #3)

4. To reduce morbidity and mortality rates from environmentally related health conditions including asthma, lead poisoning and birth defects. (ISDH Priorities #1, #2, #3 & #4)

5. To decrease tobacco use in Indiana, particularly among pregnant women. (ISDH Priorities #1, #2, & #3)

6. To integrate information systems which facilitate early identification and provision of services to children with special health care needs. (ISDH Priorities #1 & #3)

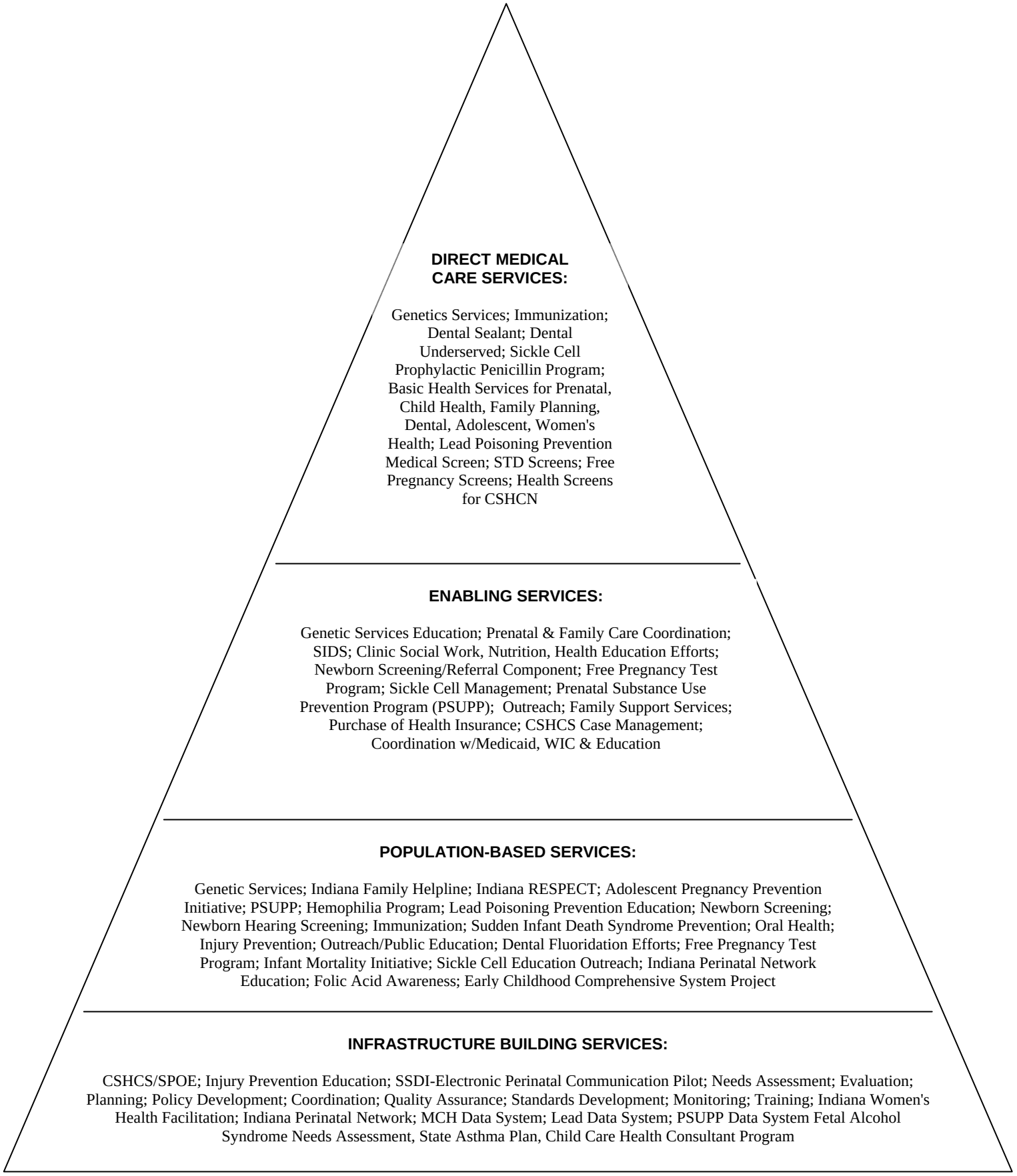
7. To reduce risk behaviors in adolescents including unintentional injuries and violence, tobacco use, alcohol and other drug use, risky sexual behavior including teen pregnancy, unhealthy dietary behaviors and physical inactivity. (ISDH Priorities #1, #2, & #3)

8. To reduce obesity in Indiana. (ISDH Priorities #1, #2, & #3)

9. To reduce the rates of domestic violence to women and children, child abuse and childhood injury in Indiana. (ISDH Priorities #1 & #3)

10. To improve racial and ethnic disparities in women of childbearing age, mothers, and children's health outcomes. (ISDH Priorities #1 & #3)

FIGURE 2: CORE PUBLIC HEALTH SERVICES



FY 2010 and FY 2011 Sickle Cell Trait Follow-up Services Grant Application Guidance

1. Applicant Information Page (Form A)

This is the first page of the proposal. **Complete all items on the page provided (Form A)**. The project director, the person authorized to make legal and contractual agreements for the applicant agency, must sign and date this document.

2. Table of Contents (created by applicant)

The table of contents must indicate the page where each section begins, including appendices.

3. Sickle Cell Trait Follow-up Services Proposal Narrative

A. Summary (created by applicant)

Begin this page with the Title of Project as stated on the Applicant Information Page. The summary will provide the reviewer a succinct and clear overview of the proposal. The summary should:

- Relate to Sickle Cell program services only;
- Address project's capacity to add the services described in this application;
- Describe how the project will provide these services;
- Justify the need for the funds being provided by this grant;
- Emphasize accomplishments/progress made toward previously identified objectives and outcomes; and
- Indicate the percentage of the target population served by your project and the percentage of racial/ethnic minority clients among your clients served.

B. Forms B-1 and B-2

All information on the Project Description Forms (Forms B-1 and B-2) must be completed. Indicate how many clients will be served for FY 2010 and FY 2011. This summary form with its narrative will become part of the grant agreement and will also be used as a fact sheet on the project. Form B-2 requests specific information on each clinic site. The following information should be included:

FORM B-1
Project Description (created by applicant)

- The Project Description must include, at a minimum, a history of the project, problems to be addressed, and a summary of the objectives and work plan. Any other information relevant to the project may also be included, but this should be an abstract of the Project Summary described in section A. *Hint: If it runs to more than one page, you've written too much.*
- May not be more than one page, but may be single-spaced.

FORM B-2

- The "Target population and estimated number to be served" on Form B-2 is for individual clinic site(s) and is the number to be served with Newborn Screening (NS) and NS matching funds.
- The "NS Budget for Site" is the estimated NS and NS matching funds budgeted for the individual clinic site.
- The "Services Provided in NS Budget Site" should include only those services provided with NS and NS matching funds.

- The "Other Services Provided at Site" section should include all services offered at clinic site(s) other than NS and NS matching funded services.

4. Applicant Agency Description (created by applicant)

Note: Large organizations should write this description for the unit directly responsible for administration of the project.

This description of the sponsoring agency should:

- Identify strengths and specific accomplishments pertinent to this proposal;
- Include a discussion of the administrative structure within which the project will function within the total organization **(NOTE: Applicants should attach an organization chart.)**;
- Identify project locations and discuss how they will be an asset to the project; and
- Include a discussion on the collaboration that will occur between the project and other organizations and healthcare providers. The discussion should identify the role of other collaborative partners and specify how each collaborates with your organization. You may attach MOUs, MOAs, and letters of support.

5. Outcome and Performance Objectives and Activities

Sickle Cell Trait Follow-up Services projects have mandatory related Performance Measures (PM) (see pages 12 –20).

Pages 12 – 20 provide the format for applicants to indicate the goal (Annual Performance Objective) for each Performance Measure, the baseline from which the project will improve or maintain the Performance Measures, and the activities on which the project will focus to impact the performance measure (Supporting Activities). Activities must reflect a comprehensive plan to achieve the objective. Some PM tables list required activities. Projects applying for these Performance Measures must list additional activities to accomplish the objective.

For each activity on the table, the applicant must indicate a clear and objective method to measure and document the activity, the documentation that will be used, and the staff position that will be responsible for implementing, measuring, and documenting that activity.

Grantee is expected to fulfill the requirements of Indiana's Newborn Screening Law and the ISDH Priority Health Initiatives as outlined in the Performance Measures for this funding opportunity. For a list of the ISDH Priority Health Initiatives, see pages 4 – 5 of this application.

Applicants are to complete the Sickle Cell Trait Follow-up Services Performance Measures on pages 12 – 20. There is an additional blank table for optional project-specific performance measures, objectives and activities that an applicant may add based on local needs. This blank table should be copied for each additional objective and activities added by the project. Project-specific activities will be evaluated as part of the quality evaluation of the project. **Applicants are strongly encouraged to discuss development of project-specific performance measures with MCSHC consultants before submitting them with the grant application.**

Pages 12 – 22 are to be used by grantees to monitor progress on each activity and to submit in the Annual Performance Report for FY 2010 and FY 2011 after each year is completed. The columns on the Performance Measures forms labeled "Activity Status," "Documentation Used," "Staff Responsible," and "Comments/Adjustments" are only to be completed and submitted with the FY 2010

and FY 2011 Annual Performance Reports. MCSHC consultants will contact projects quarterly to monitor progress on the activities and provide technical assistance. All applicants are required to collect data for monitoring purposes. See Appendix A (the Annual Performance Report) for required monitoring data elements. This information will be reported in the FY 2010 and FY 2011 Annual Performance Reports.

6. Evaluation Plan

NOTE: This should be a separate narrative section. Evaluation methods reflected on the Performance Measures Tables should be included in the overall Evaluation Plan.

A project evaluation plan should have two parts: 1) an evaluation plan to determine whether the evidence-based interventions/activities are working to impact both the specific objective goal and the priorities and 2) a quality assurance evaluation plan to ensure that services are performed well.

In the first part, discuss the methodology for measuring the achievement of activities. The plan should include intermediate (e.g. monthly, quarterly) measures of activities as well as assessment at the end of the funding period. An effective evaluation requires that:

- Project-specific activities to meet objectives are clear and measurable;
- Plan explains how evaluation methods reflected on the Performance Measure forms will be incorporated into the project evaluation;
- Staff member(s) responsible for the evaluation is/are identified;
- Plan includes explanation of what data will be collected and how it will be collected;
- Plan lists how and to whom data will be reported;
- Appropriate methods are used to determine whether measurable activities and objectives are on target for being met; and
- If activities and objectives are identified as off-target during an intermediate or year-end evaluation and improvement is necessary to meet goals, staff member(s) responsible for revisiting activities to make changes which may lead to improved outcomes is/are identified.

In the second part, discuss:

- Methods used to evaluate quality assurance (e.g. chart audits, patient surveys, presentation evaluations, observation); and
- Methods used to address identified quality assurance problems.

7. Staff

List all staff that will work on the project. Include name, job title, primary duties, and number of hours per week for each staff member. *Hint: Make sure the number of staff hours reflected in this list agrees with the staff hours total listed on the Budget Summary page.*

Describe the relevant education, training, and work experience of the staff that will enable them to successfully develop, implement, and evaluate the project. Submit job descriptions and curriculum vitae of key staff as an appendix. Copies of current professional licenses and certifications must be on file at the organization. In this section you must show that:

- Staff is qualified to operate proposed program;
- Staffing is adequate; and
- Job descriptions and curriculum vitae (CVs) of key staff are included as an appendix.

8. Facilities

Describe the facilities that will house project services. Address the adequacy, accessibility for individuals with disabilities in accordance with the Americans with Disabilities Act of 1990, and assure that project facilities will be smoke-free at all times. Hours of operation must be posted and visible from outside the facility. (Include evening and weekend hours to increase service accessibility and indicate hours of operation at each site on Form B-2.)

In this section you must demonstrate that:

- Facilities are adequate to house the proposed program;
- Facilities are accessible for individuals with disabilities;
- Facilities will be smoke-free at all times; and
- Hours of operation are posted and visible from outside the facility.

9. Budget and Budget Narrative

NOTE: Do not combine budget information for FY 2010 and FY2011. You must complete separate budget pages for each fiscal year.

In this section, you must demonstrate that:

- All expenses are directly related to project;
- The relationship between budget and project objectives is clear; and
- The time commitment to the project is identified for major staff categories and is adequate to accomplish project objectives.

Complete this entire section by providing budget information for FY 2010 and for FY 2011. The budget is an estimate of what the project will cost. Complete the provided standard budget forms (NS Budget pages 1, 2, and 3) according to directions. Do not substitute a different format. Projects do not need to include matching funds. However, any additional source(s) of funds that support services should be reported under non-matching funds.

NOTE: A Budget Narrative form is provided. Do not substitute a different format.

The budget narrative must include a justification for every line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the Newborn Screening (NS) budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties.

In-state travel information must include miles, reimbursement, and reason for travel. Travel reimbursement may not exceed State rates. Currently, the in-state travel reimbursement is $0.44 per mile.

Complete Form C – List all ISDH funding received by proposing organization in FY 2009.

Check for internal consistency among the budget forms:

- Budget pages 1, 2, and 3 are complete for each year
- Budget narratives include justification for each line item and are completed for each year
- Budget correlates with project duration
- Funding received for ISDH Form C is complete
- Information on each budget form is consistent with information on all other budget forms

10. Minority Participation

All applicants must include a statement regarding minority participation in the planning and operation of their MCH program. Minority individuals and/or organizations should be involved in planning and evaluating the project to ensure services are adequate for the minority community. Projects are also encouraged to seek to do business with Minority-Owned Business Enterprises to help provide services or operational support for the project. For a list of certified Minority-Owned Business Enterprises, see http://www.in.gov/idoa/minority/Certifications.xls.

11. Endorsements

Submit letters of support and memoranda of understanding (MOU) that demonstrate a commitment to collaboration between the applicant agency and other relevant community organizations. Letters of support and MOUs must be current. Each application must include at least three letters of support from or MOUs with relevant agencies.

Applicants are <u>not</u> required to obtain the signature(s) of or send a support letter(s) to the local health officer(s) in each county where services are proposed. Applicants may enter "N/A" for this line on Form A.

Projects are also strongly encouraged to work with their Local Public Health Coordinators to enhance preparedness (ISDH Priority Health Initiative #4).

Checklist – Letters of Support and Memoranda of Understanding:

- Endorsements are from organizations able to effectively coordinate programs and services with applicant agency.
- Memoranda of Understanding (MOU) clearly delineate the roles and responsibilities of the involved parties in the delivery of community-based health care.
- Endorsements and/or MOUs are current.
- MOUs with other genetic services serving the same geographic area, including MCH-funded and MCH non-funded services, clearly state how the services will work together.
- Letters and a summary of the proposed program have been sent to all health officers in jurisdictions within the proposed service area (unless health officer(s) has/have signed Form A).

Questions regarding this grant application may be directed to Vanessa Daniels (VDaniels@isdh.IN.gov / 317-233-1241) or Bob Bowman (bobbowman@isdh.IN.gov / 317-233-1231).

REQUIRED FORMS FOR SICKLE CELL TRAIT FOLLOW-UP SERVICES PROVIDERS

1) Form A: Applicant Information

2) Form B-1 and B-2: Sickle Cell Trait Follow-up Project Description

3) Form C: Funding Currently Received by Your Agency from ISDH

4) Performance Measures 1 - 4

Note: *Providers serving counties with significant numbers of minority populations must identify activities for Performance Measures 1 and 3 related to outreach and marketing to the minority populations to provide culturally competent services to those populations.*

FY 2010 – 2011 OBJECTIVES and ACTIVITIES

Performance Measure 1: Provide educational, counseling, and follow-up services to families of children originally referred by the Indiana Newborn Screening (NBS) laboratory with Sickle Cell trait or trait of another hemoglobinopathy.

Directions for Completion

To complete these tables, please state your projected goals (of the percentage of children referred by the NBS laboratory that will receive appropriate follow-up services) for FY 2010 and FY 2011.

Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in meeting or exceeding expectations in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Note: The ISDH Genomics and Newborn Screening Program expects that at least **90%** of the families of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy will receive educational, counseling, and follow-up services.

Performance Objective 1a:

Ensure that at least ____% **(estimated goal)** of families of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy receive educational, counseling and follow-up services.

PO 1a: Educational, counseling, and follow-up services provided to families of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait for another hemoglobinopathy		
(b) Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait for another hemoglobinopathy whose families received the ISDH Sickle Cell Trait educational packet		
Goal: Percentage of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait for another hemoglobinopathy whose families received the ISDH Sickle Cell Trait educational packet.		
Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait for another hemoglobinopathy whose families received direct counseling and/or follow-up services		

Performance Objective 1b:

Ensure that ____% **(estimated goal)** of primary care providers (PCPs) of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy receive the educational, counseling, and follow-up materials provided to their patients' families.

PO 1b: Contact with PCPs of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy that have a PCP		
(b) Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy whose PCPs received the same educational, counseling, and follow-up materials that were provided to their patients' families		
Goal: Percentage of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy whose PCPs received the same educational, counseling, and follow-up materials that were provided to their patients' families		

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 1. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments shall be filled in on the quarterly and annual reports; **Do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments /Adjustments
Provide assistance in utilizing local resources to > 90% of patients/families of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or with trait of another hemoglobinopathy.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Provide > 90 % of PCPs of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or with trait of another hemoglobinopathy with the same follow-up materials originally provided to the patient's family.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

FY 2010 – 2011 OBJECTIVES and ACTIVITIES

Performance Measure 2: Provide educational, counseling, and follow-up services to families of children with Sickle Cell trait or trait of another hemoglobinopathy.

Directions for Completion

To complete this table, please state your projected goals (of the percentage of families who contact the grantee seeking information and receiving services) for FY 2010 and FY 2011.

Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in meeting or exceeding expectation in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Note: The ISDH Genomics and Newborn Screening Program expects at least **95%** of families (whose children have Sickle Cell trait or trait of another hemoglobinopathy) who contact the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy will receive appropriate educational, counseling, and/or follow-up services.

Performance Objective 2:

Ensure that at least ____% **(estimated goal)** of families (whose children have Sickle Cell trait or trait of another hemoglobinopathy) who contact the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy receive educational, counseling, and/or follow-up services.

PO 2: Services provided to families (whose children have Sickle Cell trait or trait of another hemoglobinopathy) regarding Sickle Cell trait or trait of other hemoglobinopathies

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of children (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy		
(b) Total number of unduplicated children (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy who directly (face-to-face contact) received educational, counseling, and/or follow-up services		
(c) Total number of unduplicated children (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy who indirectly (phone call) received educational, counseling, and/or follow-up services		

Total number of <u>children</u> (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy who received the ISDH Sickle Cell Trait educational packet.		
<u>Goal:</u> Percentage of children (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy who received either <u>direct</u> or <u>indirect</u> educational, counseling, and/or follow-up services		

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 2. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports**. Do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Provide a hard copy of appropriate resource information to > 95% of families that contacted the grantee's center(s) seeking information.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Collect evaluation forms from parents. Use feedback from these evaluation sheets to modify and improve services.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

FY 2010 – 2011 OBJECTIVES and ACTIVITIES

Performance Measure 3: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

Directions for Completion

To complete these tables, please state your projected goals (of the percentage of new families seen in person that receive education) for FY 2010 and FY 2011.

Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in meeting or exceeding expectation in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Note: The ISDH Genomics and Newborn Screening Program expects at least **90%** of new families seen by the grantee to be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid.

Performance Objective 3a:

Ensure that _____% **(estimated goal)** of new families seen in person will be educated to the ***negative*** effects of ***smoking*** during pregnancy.

PO 3a: New families seen in person and educated to the *negative* effects of *smoking* during pregnancy

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of new families with members who smoke and were seen in person that received **smoking cessation education**		
(b) Total number of new families with members who reportedly smoke and were seen in person		
Goal: Percentage of new families with members who smoke and were seen in person that received **smoking cessation education**		

Performance Objective 3b:
Ensure that _____% **(estimated goal)** of new families seen in person will be educated to the ***negative*** effects of ***consuming alcohol*** during pregnancy.

PO 3b: New families who were seen in person and educated to the *negative* effects of *alcohol consumption* during pregnancy

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of new families who were seen in person and received education on **alcohol-related birth defects**		
(b) Number of new families who were seen in person		
Goal: Percentage of new families who were seen in person and received education on **alcohol-related birth defects**		

Performance Objective 3c:
Ensure that _____% **(estimated goal)** of new families seen in person that will be educated to the ***positive*** effects of taking ***folic acid***.

PO 3c: New families seen in person and educated to the *positive* effects of taking *folic acid*

Annual Outcome Objective	FY 2010	FY 2011
(a) Number of new families who were seen in person and received **folic acid education**		
(b) Number of new families who were seen in person		
Goal: Percentage of new families who were seen in person and received **folic acid education**		

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 3. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports. **Do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Develop and incorporate into your patient intake forms a protocol asking patients if they took folic acid preconceptionally or smoked and/or consumed alcohol during pregnancy.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Ensure that greater than 90% of patients who admit to smoking, drinking, or using drugs are referred to appropriate community cessation programs (e.g. Prenatal Substance Use Prevention Program (PSUPP), Indiana Tobacco QuitLine, Alcoholics Anonymous).*			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

***** Please see Hemoglobinopathy Services Definitions on page 65 for contact information for available ISDH family support resources.

FY 2010 – 2011 OBJECTIVES and ACTIVITIES

Performance Measure 4: Provide educational presentations to the general public.

Directions for Completion

To complete this table please write your projected goals (the total number of presentations) for FY 2010 and FY 2011.

Only complete for patients in your project population. The numbers reported in this table will be used to evaluate your performance in meeting expectations in the annual report. Gray areas will be filled in on the quarterly and annual reports; **do not** fill them in at this time.

Note: A ***minimum*** of **four (4)** presentations are to be given to the general public. Give estimates for current year for each of the types of presentations listed below. Please give actual numbers for each quarter. Do **not** count one talk under two different audiences.

Performance Objective 4:
Project staff will provide ____ presentations.

PO 4: Sickle Cell Presentations

Main Audience	FY 2010	FY 2011
General Public		
Other presentations		
Goal: **Total Number of Presentations**		

Supporting Activities Table

Directions: Please state how progress of this activity will be documented and list the staff member(s) that will be responsible for ensuring the activity is completed. Please develop and insert at least (one) additional measurable activity in the blank spaces at the bottom of this table that you believe will assist in meeting Performance Objective 4. Feel free to use additional pages as necessary. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports. **Do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Collect evaluation sheets for each presentation; use feedback from these evaluation sheets to modify and improve presentations to follow.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Determine the size of each audience. (**Note**: Attendance or evaluation sheets may be used to determine these numbers.)			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

Note: Application Evaluation Plan should include a sample evaluation sheet and a description of how scores will be compiled. Modifications to the presentations based on applicable feedback shall be documented.

FY 2010 – 2011 OBJECTIVES and ACTIVITIES

Project Specific Performance Measure:

Project Specific Performance Objective:

Service Projections

	FY 2008 (Baseline)	FY 2009	FY 2010	FY 2011

Supporting Activities Table

Directions: State which staff members will be responsible for the following activities, the current status of each activity, and provide a brief comment on how this activity is to be completed. Additional activities can be added at the bottom of this table. The Activity Status and Comments/Adjustments will be filled in on the quarterly and annual reports **do not** fill them in at this time.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

BUDGET INSTRUCTIONS

Materials Provided: The following materials are included in this packet:

Instructions
Definitions – Revenue Accounts
Chart of Account Codes
Non-allowable Expenditures
Budget Narrative Form (NS Budgets for FY 2010 & FY 2011)
Section I - Sources of Anticipated Revenue (NS Budgets for FY 2010 & FY 2011)
Section II - Estimated Costs and Clients to be Served (NS Budgets for FY 2010 & FY 2011)
Anticipated Expenditures (NS Budgets for FY 2010 & FY 2011)

INSTRUCTIONS

Review all materials and instructions before beginning to complete your budget. If you have any questions relative to completing your project's budget, contact:

Vanessa Daniels **VDaniels@isdh.IN.gov** **317/233-1241**

In completing the packet, remember that all amounts should be rounded to the nearest dollar.

Completing the Budget Narrative Form

NOTE: Create a separate budget for Fiscal Year (FY) 2010 and for FY 2011.

- FY 2010 runs from July 1, 2009 through June 30, 2010.
- FY 2011 runs from July 1, 2010 through June 30, 2011.

The Budget Narrative Form does not provide a column for NS Matching Funds but does provide a column for Total NS + NS Matching.

Schedule A

For each individual staff member, provide the name of the staff member and a brief description of his/her role in the project. If multiple staff members are entered in one row (for instance, 111.400 Nurses), a single description may be provided, if applicable. Each staff member must be listed by name. Calculations must be provided for each staff member in the Calculations column. This calculation should be in the form salary ($) = $/hour x hours/week x weeks/year. Fringe may be calculated for all staff. If different fringe rates are used for different categories of staff, fringe may be calculated by category.

Schedule B

List each contract, each piece of equipment, general categories of supplies (office supplies, medical supplies, etc.), travel by staff members, and significant categories in Other Expenditures (such as Indirect) in the appropriate column. Provide calculations as appropriate. Calculations are optional for Contractual Services. Travel must be calculated for each staff member who will be reimbursed and may not exceed $0.44 per mile.

Completing Section I - Sources of Anticipated Revenue

List all anticipated revenue according to source. If the project was funded in previous years with Newborn Screening funds, estimate the cash you expect to have available from the previous year. This estimated cash-on-hand should be indicated by 400.1 and/or 400.2, respectively. If the estimated cash balance is negative, please list the estimate as $0. All revenue used to support the project operations must be budgeted.

Projects do not need to include matching funds. However, any additional source(s) of funds that support services should be reported under non-matching funds. Non-matching funds are additional sources of support that are not included in the match. These funds are not subject to NS guidelines.

In the space at the bottom of Section I, please be sure to indicate how many hours are worked in a "normal" work week. This is usually determined by the applicant agency's policies.

Completing Section II - Estimated Cost and Clients to be Served

It is essential that this form be completed accurately because the information will be used in your contract. Your project will be accountable for the services that are listed and the number estimated to be served.

Estimate the NS Cost per Service listed (e.g. how much of your NS grant you propose to expend in each service). Figures for this are listed by service category in the column entitled "**NS COST PER SERVICE."** The total at the bottom of this column should equal the MCH grant award request.

Estimate the NS Matching Funds allocated per service listed (e.g., how much of the NS match you propose to expend in each service). The total at the bottom of this column should equal the total match you are adding to the NS award to fund this program.

Estimate the number of unduplicated clients by service category who will receive each service in the column titled **"TOTAL UNDUPLICATED # ESTIMATED TO BE SERVICED"** by both NS and NS Matching Funds.

(The rest of this page left blank intentionally)

DEFINITIONS - REVENUE ACCOUNTS

Account	Account Title	Description
414	NS Grant Request	Funds requested as reimbursement from the Indiana State Department of Health for project activities.
Matching Funds*		*Cash used for project activities that meet the matching requirements and are designated by the project as matching funds.* *****
417	Local Appropriations	Monies appropriated from the local government to support project activities, e.g., local health maintenance fund.
419	First Steps	Monies received from First Steps for developmental disabilities services.
421	Donations – Cash	Monies received from donors to support project activities.
424	United Way/March of Dimes	Monies received from a United Way/March of Dimes agency to support project activities.
432	Title XIX – Hoosier Heathwise and Title XXI, CHIP	Monies received from Hoosier Heathwise and CHIP as reimbursement provided for services to eligible clients.
434	Private Insurance	Monies received from health insurers for covered services provided to participating clients.
436	Patient Fees	Monies collected from clients for services provided based on NS approved sliding fee schedule.
437	Other Matching	Other income directly benefiting the project and not classified above which meets matching requirements.
Nonmatching Funds		*Funds which do not meet matching requirements or are not designated as matching funds.*
433	Title XX	Monies received from State Title XX agency (Family and Social Services Administration) for reimbursement provided for family planning services to eligible clients.
439	Other Nonmatching	Income directly benefiting the project and not classified above that does not meet matching requirements or that is in excess of the required/ designated match amount.
Estimated Cash on Hand as of June 30th of last FY		*Monies received by the project during the previous fiscal years and not yet used for project expenditures.*
400.1	Matching Cash on Hand	Those monies received during previous years from sources classified as matching.
400.2	Nonmatching Cash on Hand	Those monies received during previous years from sources classified as nonmatching.

***** Matching requirements include:

1. Amounts are verifiable from grantee's records.
2. Funds are not included as a matching source for any other federally assisted programs.
3. Funds are allocated in the approved current budget.
4. Funds are spent for the NS project as allocated and the expenditure of these funds is reported to NS Services.
5. Funds are subject to the same expenditure guidelines as NS grant funds (i.e., no food, entertainment or legislative lobbying).

SCHEDULE A - CHART OF ACCOUNT CODES

111.000 PHYSICIANS

- Clinical Geneticist
- Family Practice Physician
- General Family Physician
- Genetic Fellow
- Medical Geneticist
- Neonatologist
- OB/GYN
- Other Physician
- Pediatrician
- Resident/Intern
- Substitute/Temporary
- Volunteer

111.150 DENTISTS/HYGIENISTS

- Dental Assistant
- Dental Hygienist
- Dentist
- Substitute/Temporary
- Volunteer

111.200 OTHER SERVICE PROVIDERS

- Audiologist
- Child Development Specialist
- Community Educator
- Community Health Worker
- Family Planning Counselor
- Genetic Counselor (M.S.)
- Health Educator/Teacher
- Occupational Therapist
- Outreach Worker
- Physical Therapist
- Physician Assistant
- Psychologist
- Psychometrist
- Speech Pathologist
- Substitute/Temporary
- Volunteer

111.350 CARE COORDINATION

- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Social Worker (L.S.W.)
- Physician
- Registered Dietitian
- Registered Nurse
- Social Worker (B.S.W.)
- Social Worker (M.S.W.)
- Substitute/Temporary
- Volunteer

111.400 NURSES

- Clinic Coordinator
- Community Health Nurse
- Family Planning Nurse Practitioner
- Family Practice Nurse Practitioner
- Licensed Midwife
- Licensed Practical Nurse
- OB/GYN Nurse Practitioner
- Other Nurse
- Other Nurse Practitioner
- Pediatric Nurse Practitioner
- Registered Nurse
- School Nurse Practitioner
- Substitute/Temporary
- Volunteer

111.600 SOCIAL SERVICE PROVIDERS

- Caseworker
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Social Worker (L.S.W.)
- Counselor
- Counselor (M.S.)
- Social Worker (B.S.W.)
- Social Worker (M.S.W.)
- Substitute/Temporary
- Volunteer

111.700 NUTRITIONISTS/DIETITIANS

Dietitian (R.D. Eligible)	Registered Dietitian
Nutrition Educator	Substitute/Temporary
Nutritionist (Master Degree)	Volunteer

111.800 MEDICAL/DENTAL/PROJECT DIRECTOR

Dental Director	Project Director
Medical Director	

111.825 PROJECT COORDINATOR

111.850 OTHER ADMINISTRATION

Accountant/Finance/Bookkeeper	Laboratory Technician
Administrator/General Manager	Maintenance/Housekeeping
Clinic Aide	Nurse Aide
Clinic Coordinator (Administration)	Other Administration
Communications Coordinator	Programmer/Systems Analyst
Data Entry Clerk	Secretary/Clerk/Medical Record
Evaluator	Substitute/Temporary
Genetic Associate/Assistant	Volunteer
Laboratory Assistant	

115.000 FRINGE BENEFITS

200.700 TRAVEL

Conference Registrations	Out-of-State Staff Travel (only available with non-matching funds)
In-State Staff Travel	

200.800 RENTAL AND UTILITIES

Janitorial Services	Rental of Space
Other Rentals	Utilities
Rental of Equipment and Furniture	

200.850 COMMUNICATIONS

Postage (including UPS)	Reports
Printing Costs	Subscriptions
Publications	Telephone

200.900 OTHER EXPENDITURES

Insurance and Bonding	Insurance premiums for fire, theft, liability, fidelity bonds, etc. Malpractice insurance premiums cannot be paid with grant funds. However, matching and nonmatching funds can be used.
Maintenance and Repair --	Maintenance and repair services for equipment, furniture, vehicles, and/or facilities used by the project.
Other	Approved items not otherwise classified above.

EXAMPLES OF EXPENDITURE ITEMS THAT WILL NOT BE ALLOWED

The following may not be claimed as project cost for NS projects and may not be paid for with NS or NS Matching Funds:

1. Construction of buildings, building renovations;
2. Depreciation of existing buildings or equipment;
3. Contributions, gifts, donations;
4. Entertainment, food;
5. Automobile purchase / rental;
6. Interest and other financial costs;
7. Costs for in-hospital patient care;
8. Fines and penalties;
9. Fees for health services;
10. Accounting expenses for government agencies;
11. Bad debts;
12. Contingency funds;
13. Executive expenses (car rental, car phone, entertainment);
14. Client travel; and/or
15. Legislative lobbying.

The following may be claimed as project costs for NS projects and may be paid for only with specific permission from the Director of Maternal and Children's Special Health Care Services, ISDH:

1. Equipment;
2. Out-of-state travel; and
3. Dues to societies, organizations, or federations.

All equipment costing $1,000 or more that is purchased with NS and/or NS Matching Funds shall remain the property of the State and shall not be sold or disposed of without written consent from the State.

For further clarification on allowable expenditures, please contact:

Vanessa Daniels, Grants Manager, MCSHC, VDaniels@isdh.IN.gov or 317/233-1241

FY 2010 Budget Narrative

The budget narrative must include a justification for every line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the Newborn Screening (NS) budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must include miles, reimbursement ($0.44 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request).

Account Number and Item	Description and Justification	Calculations	Total NS	Total NS + NS MATCHING
	For each personnel entry, include name, title and brief description of his/her role in the project (i.e. provides direct services). List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.	Personnel = $/hr X hrs per week X weeks per year Fringe = salary X fringe rate	Total to be charged to NS	Total cost charged to NS and NS Matching funds
Schedule A				
111.000 Physicians				
111.150 Dentists / Hygienists				
111.200 Other Service Providers				
111.350 Care Coordination				
111.400 Nurses				
111.600 Social Service Providers				
111.700 Nutritionists / Dietitians				
111.800 Medical/Dental / Project Director				
111.825 Project Coordinator				
111.850 Other Administration				
115.000 Fringe Benefits				

Account Number and Item	Description and Justification	Calculations	Total NS	Total NS + NS MATCHING
	List each contract and explain its purpose. List each piece of equipment separately along with price for one. List travel entries by the staff that will be reimbursed for travel and explain how this travel serves the project. List rent and utilities costs separately for each facility. If possible, itemize projected other expenditures.	Equipment = price for 1 X number required. Travel = $0.44 X miles for each staff member being reimbursed for travel.	Total to be charged to NS	Total cost charged to NS and NS Matching funds
Schedule B				
200.000 Contractual Services				
200.500 Equipment				
200.600 Consumable Supplies				
200.700 Travel				
200.800 Rental and Utilities				
200.850 Communications				
200.900 Other Expenditures				
		SUBTOTAL SCHEDULE A		
		SUBTOTAL SCHEDULE B		
		TOTAL SCHEDULES A&B		

FY 2011 Budget Narrative

The budget narrative must include a justification for every line item. Each narrative statement should describe what the specific item is, how the specific item relates to the project, and how the amount shown in the Newborn Screening (NS) budget was derived. Staff information must include staff name, position, hours worked on the project, salary, and a brief description of duties. In-state travel information must include miles, reimbursement ($0.44 per mile), and reason for travel. All travel reimbursement must be within ISDH travel policy (available on request).

Account Number and Item	Description and Justification	Calculations	Total NS	Total NS + NS MATCHING
	For each personnel entry, include name, title and brief description of his/her role in the project (i.e. provides direct services). List all appropriate staff in the box provided. If there are 4 nurses, list all 4 in the same box.	Personnel = $/hr X hrs per week X weeks per year Fringe = salary X fringe rate	Total to be charged to NS	Total cost charged to NS and NS Matching funds
Schedule A				
111.000 Physicians				
111.150 Dentists / Hygienists				
111.200 Other Service Providers				
111.350 Care Coordination				
111.400 Nurses				
111.600 Social Service Providers				
111.700 Nutritionists / Dietitians				
111.800 Medical/Dental / Project Director				
111.825 Project Coordinator				
111.850 Other Administration				
115.000 Fringe Benefits				

Account Number and Item	Description and Justification	Calculations	Total NS	Total NS + NS MATCHING
	List each contract and explain its purpose. List each piece of equipment separately along with price for one. List travel entries by the staff that will be reimbursed for travel and explain how this travel serves the project. List rent and utilities costs separately for each facility. If possible, itemize projected other expenditures.	Equipment = price for 1 X number required. Travel = $0.44 X miles for each staff being reimbursed for travel.	Total to be charged to NS	Total cost charged to NS and NS Matching funds
Schedule B				
200.000 Contractual Services				
200.500 Equipment				
200.600 Consumable Supplies				
200.700 Travel				
200.800 Rental and Utilities				
200.850 Communications				
200.900 Other Expenditures				
		SUBTOTAL SCHEDULE A		
		SUBTOTAL SCHEDULE B		
		TOTAL SCHEDULES A&B		

SECTION I - BUDGET
SOURCES OF ANTICIPATED REVENUE FOR FISCAL YEAR 2010

Project Title: _____ Project # _____

Applicant Agency: _____

414 Newborn Screening Grant Request

(A) $_____

MATCHING FUNDS - CASH

417	Local Appropriations	$_____
419	First Steps	$_____
421	Cash Donations	$_____
424	United Way/March of Dimes	$_____
432	Hoosier Heathwise/CHIP (Titles XIX / XXI)	$_____
434	Private Insurance	$_____
436	Patient Fees	$_____
437	Other Matching	$_____

TOTAL MATCHING FUNDS (Cash) (B) $_____

NONMATCHING FUNDS - CASH

433	Title XX	$_____
439	Other	$_____

TOTAL NONMATCHING FUNDS (C) $_____

ESTIMATED CASH ON HAND AS OF June 30, 2009

400.1	Matching	$_____
400.2	Nonmatching	$_____

TOTAL ESTIMATE (400.1 + 400.2) (D) $_____

TOTAL PROJECT REVENUE (A)+(B)+(C)+(D) (E) $_____

A Full-Time Employee Works _____ Hours Per Week.

SECTION I - BUDGET
SOURCES OF ANTICIPATED REVENUE FOR FISCAL YEAR 2011

Project Title: _____ Project # _____

Applicant Agency: _____

414 Newborn Screening Grant Request

(A) $_____

MATCHING FUNDS - CASH

417	Local Appropriations	$_____
419	First Steps	$_____
421	Cash Donations	$_____
424	United Way/March of Dimes	$_____
432	Hoosier Heathwise/CHIP (Titles XIX / XXI)	$_____
434	Private Insurance	$_____
436	Patient Fees	$_____
437	Other Matching	$_____

TOTAL MATCHING FUNDS (Cash) (B) $_____

NONMATCHING FUNDS - CASH

433	Title XX	$_____
439	Other	$_____

TOTAL NONMATCHING FUNDS (C) $_____

ESTIMATED CASH ON HAND AS OF June 30, 2010 (may use estimate for 2009)

400.1	Matching	$_____
400.2	Nonmatching	$_____

TOTAL ESTIMATE (400.1 + 400.2) (D) $_____

TOTAL PROJECT REVENUE (A)+(B)+(C)+(D) (E) $_____

A Full-Time Employee Works _____ Hours Per Week.

SECTION II - BUDGET
NS AND MATCHING FUNDS ESTIMATED COST AND CLIENTS TO BE SERVED FISCAL YEAR 2010

Project Title:_____ Project #_____

Applicant Agency: _____

Service	NS Cost Per Service[1]	NS Matching Funds Allocated Per Service[3]	Total Unduplicated # Estimated To Be Served by NS & NS Matching Funds[5]
Sickle Cell Trait Follow-up Coordination of Medical/ Community Services			
Other (please list)			
TOTAL	[2]	[4]	

1 Cells in this column should reflect the amount of the NS grant award that is estimated to be spent on specific services, e.g., prenatal care, family planning. Do not enter a per client cost.

2 This cell should reflect the total grant request (line A from NS Budget – 1).

3 Cells in this column should reflect the amount of NS matching funds estimated to be spent on specific services.

4 This cell should reflect total NS matching funds estimated to be spent on NS services (line B from NS Budget – 1).

5 Cells in this column should reflect the unduplicated number of clients you estimated to be served with NS and NS matching funds during the fiscal year.

SECTION II - BUDGET
NS AND MATCHING FUNDS ESTIMATED COST AND CLIENTS TO BE SERVED FISCAL YEAR 2011

Project Title:_____ Project #_____

Applicant Agency: _____

Service	NS Cost Per Service[1]	NS Matching Funds Allocated Per Service[3]	Total Unduplicated # Estimated To Be Served by NS & NS Matching Funds[5]
Sickle Cell Trait Follow-up Coordination of Medical/ Community Services			
Other (please list)			
TOTAL	[2]	[4]	

1 Cells in this column should reflect the amount of the NS grant award that is estimated to be spent on specific services, e.g., prenatal care, family planning. Do not enter a per client cost.

2 This cell should reflect the total grant request (line A from NS Budget – 1).

3 Cells in this column should reflect the amount of NS matching funds estimated to be spent on specific services.

4 This cell should reflect total NS matching funds estimated to be spent on NS services (line B from NS Budget – 1).

5 Cells in this column should reflect the unduplicated number of clients you estimated to be served with NS and NS matching funds during the fiscal year.

ANTICIPATED EXPENDITURES FOR FISCAL YEAR 2010

Project Title: _____ Project #_____ Applicant Agency: _____

Acct. Number	Description Number	Total Funds	GRANT FUNDS	MATCHING FUNDS									NON-MATCHING FUNDS			Normal Work Wk. Hours Budgeted on Project[1]
			NS Funds 414	Local Approp. 417	First Steps 419	Cash Donations 421	United Way/ March of Dimes 424	Hoosier Heathwise & CHIP XIX & XXI 432	Private Insurance 434	Patient Fees 436	Other Matching 437	Cash on Hand 400.1	Title XX 433	Other 439	Cash on Hand 400.2	
	Schedule A															
111.000	Physicians															
111.150	Dentists/Hygienists															
111.200	Other Service Providers															
111.350	Care Coordination															
111.400	Nurses															
111.600	Social Service Providers															
111.700	Nutritionists/Dietitians															
111.800	Medical/Dental/ Project Director															
111.825	Project Coordinator															
111.850	Other Administration															
115.000	Fringe Benefits															
	Schedule B															
200.000	Contractual Services															
200.500	Equipment															
200.600	Consumable Supplies															
200.700	Travel															
200.800	Rental and Utilities															
200.850	Communications															
200.900	Other Expenditures															
SUBTOTAL SCHEDULE A																
SUBTOTAL SCHEDULE B																
TOTAL																

1 Cells in this column should reflect the number of hours worked in a week by all staff in each job classification, e.g., a project with two nurses working 40 hours per week and one nurse working 20 hours per week should enter 100 hours for 111.400

ANTICIPATED EXPENDITURES FOR FISCAL YEAR 2011

Project Title: _____ Project #_____ Applicant Agency: _____

Acct. Number	Description Number	Total Funds	GRANT FUNDS	MATCHING FUNDS									NON-MATCHING FUNDS			Normal Work Wk. Hours Budgeted on Project[1]
			NS Funds 414	Local Approp. 417	First Steps 419	Cash Donations 421	United Way/ March of Dimes 424	Hoosier Heathwise & CHIP XIX & XXI 432	Private Insurance 434	Patient Fees 436	Other Matching 437	Cash on Hand 400.1	Title XX 433	Other 439	Cash on Hand 400.2	
	Schedule A															
111.000	Physicians															
111.150	Dentists/Hygienists															
111.200	Other Service Providers															
111.350	Care Coordination															
111.400	Nurses															
111.600	Social Service Providers															
111.700	Nutritionists/Dietitians															
111.800	Medical/Dental/ Project Director															
111.825	Project Coordinator															
111.850	Other Administration															
115.000	Fringe Benefits															
	Schedule B															
200.000	Contractual Services															
200.500	Equipment															
200.600	Consumable Supplies															
200.700	Travel															
200.800	Rental and Utilities															
200.850	Communications															
200.900	Other Expenditures															
SUBTOTAL SCHEDULE A																
SUBTOTAL SCHEDULE B																
TOTAL																

1 Cells in this column should reflect the number of hours worked in a week by all staff in each job classification, e.g., a project with two nurses working 40 hours per week and one nurse working 20 hours per week should enter 100 hours for 111.400

FORM A

SICKLE CELL TRAIT FOLLOW-UP SERVICES PROVIDERS
GRANT APPLICATION
FY 2010 & FY 2011

Title of Project: _____ Federal I.D. #: _____

Medicaid Provider Number: _____ FY 2009 NS Contract Amount: $_____

FY 2010 NS Amount Requested: $_____ FY 2010 Matching Funds Contributed $_____

FY 2011 NS Amount Requested: $_____ FY 2011 Matching Funds Contributed $_____

Legal Agency / Organization Name: _____

_____
Street City Zip Code

_____ _____ _____
Phone FAX E-Mail Address

_____ _____ _____
Project Director (type name) Phone E-Mail Address

_____ _____
Board President/Chairperson (type name) Phone

_____ _____
Project Medical Director (type name) Phone

_____ _____ _____
Agency CEO or Official Custodian of Funds (type name) Title Phone

_____ _____
Signature of Project Director Date

_____ _____ _____
Signature of person authorized to make legal And contractual agreement for the applicant agency Title Date

_____ _____ _____
Signature of County Health Officer (or date letter sent to County Health Officers) County Date

Are you registered with the Secretary of State? ☐ Yes ☐ No

Note: All arms of local and State government are registered with the Secretary of State. Applicants must be registered with the Secretary of State to be considered for funding.

FORM B-1

FY 2010 & FY 2011
Project Description

Project Name:		Project Number:
Address:	City, State, Zip	
Telephone Number:	Fax Number:	E-Mail Address:
Counties Served:		
Type of Organization: State ☐	Local ☐	Private Non-Profit ☐
Requested Funds: $_____ Matching Funds: $_____ Non-matching Funds: $_____ (Amounts above should reflect total for FY 2010 + total for FY 2011)		
Sponsoring Agency:		
Summarize identified needs from the needs assessment section. Include only those needs the Project will address.		
Summarize Performance Measures from Performance Measures Tables (Hint: Each identified need above should be addressed with a Performance Measure.)		

NS Project Name:	Project Number:	# Clinic Sites

Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site (include matching funds):
Counties Served:	Services Provided in NS Budget for site (include matching funds):	
Target Population and estimated number to be served with NS and matching funds:	Other services provided at site (non-NS or non-Match):	
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site (include matching funds):
Counties Served:	Services Provided in NS Budget for site (include matching funds):	
Target Population and estimated number to be served with NS and matching funds:	Other services provided at site (non-NS or non-Match):	
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site (include matching funds):
Counties Served:	Services Provided in NS Budget for site (include matching funds):	
Target Population and estimated number to be served with NS and matching funds:	Other services provided at site (non-NS or non-Match):	
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site (include matching funds):
Counties Served:	Services Provided in NS Budget for site (include matching funds):	
Target Population and estimated number to be served with NS and matching funds:	Other services provided at site (non-NS or non-Match):	
Clinic Site Address:	Clinic Schedule (days & times):	NS Budget for Site (include matching funds):
Counties Served:	Services Provided in NS Budget for site (include matching funds):	
Target Population and estimated number to be served with NS and matching funds:	Other services provided at site (non-NS or non-Match):	

FORM C

FUNDING **CURRENTLY** RECEIVED BY YOUR AGENCY
FROM THE INDIANA STATE DEPARTMENT OF HEALTH

LIST ALL SOURCES OF ISDH FUNDING

SOURCE	FISCAL YEAR	AMOUNT

TOTAL $_____

COMMENTS:

Appendix A

INDIANA STATE DEPARTMENT OF HEALTH
NEWBORN SCREENING PROGRAM
SICKLE CELL TRAIT FOLLOW-UP SERVICES PROVIDERS
ANNUAL PERFORMANCE REPORT FY 2010

PROJECT NAME: _____

PROJECT NUMBER: _____

APPLICANT AGENCY: _____

REPORTING PERIOD: FY 2010 (7/1/09 TO 6/30/10)

DATE SUBMITTED: _____ PREPARED BY: _____

I. Instructions……(Page 44)

II. Narrative……(Page 44)

III. Quality Assurance……(Page 44)

IV. Demographic Data……(Pages 44 - 46)

V. Program Monitoring Data……(Pages 46 - 50)

VI. Project Data……(Pages 51 - 61)

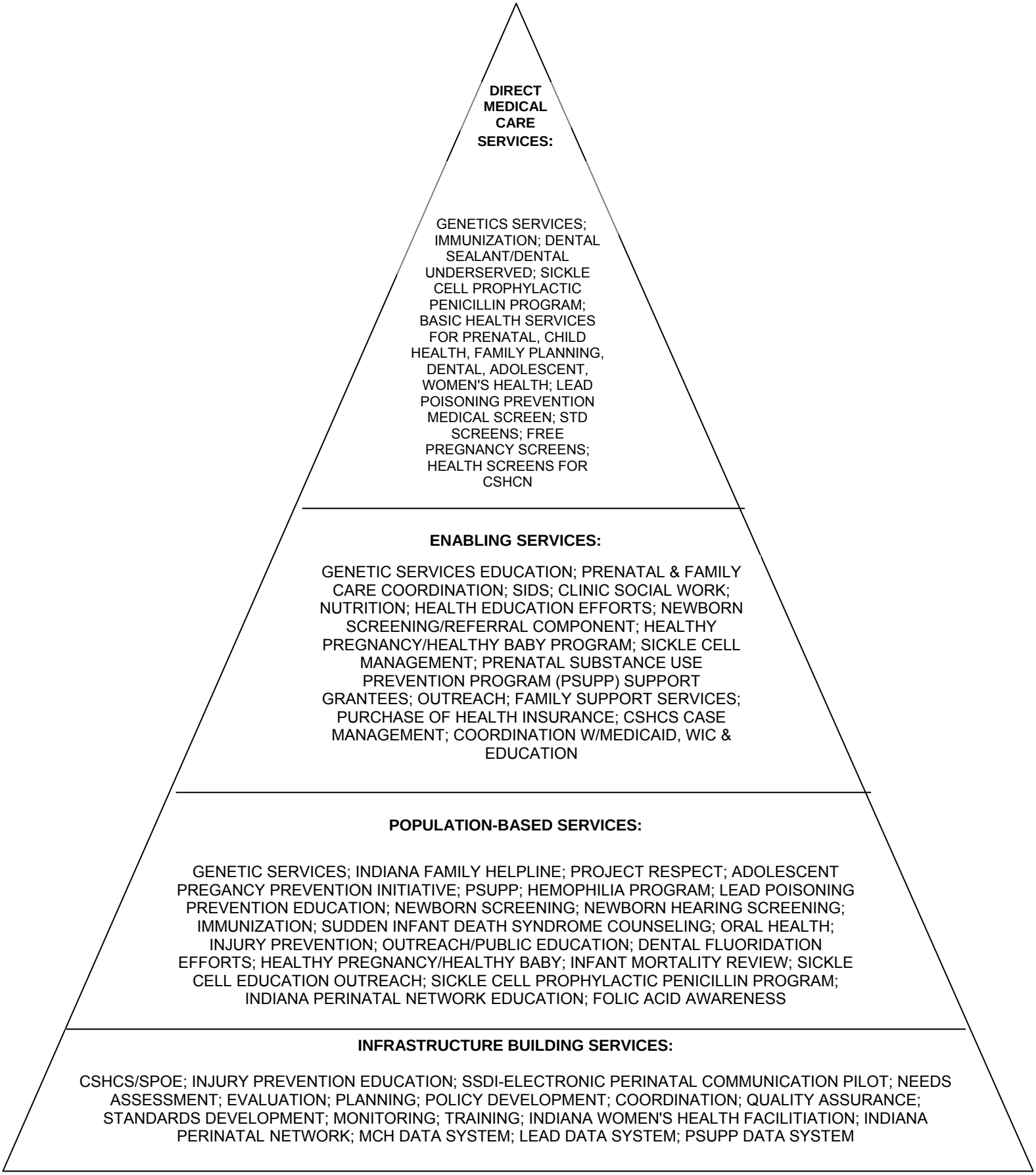
VII. Appendices……(Pages 62 - 65)

Appendix 1 Performance Objective Summary

Appendix 2 Definitions

Appendix 3 Descriptions for Final or Best Working Diagnosis Table

FIGURE1: CORE PUBLIC HEALTH SERVICES DELIVERED BY CSHCS AGENCIES



I. Instructions

Instructions are included by section in the report form.

II. Narrative

Using the categories below, describe through narrative and statistics the services provided by NS funding to women and/or children in your project during the last fiscal year. Keep the discussion brief and address only the services and activities in which your project is engaged and which are funded by NS funds. The Narrative should be supported by the statistical report and completed work plan. It should provide a complete picture of your NS program, including where your services fit into the Core Public Health Services Pyramid. As part of the description of services provided, the discussion should include the following information for each service category:

- Explain the strengths and weaknesses of the project and project accomplishments during the funding year.
- Explain any significant discrepancies between projected number served and actual number served. Significant discrepancies exist if the number served fell below or exceeded projected service levels by more than 10%.
- Explain any change in clinical or administrative procedure, including staffing changes.
- Document activities to improve communications with, outreach to, and services for racial and ethnic minorities. Include plans to reduce disparities in access to services and health outcomes.
- Complete the hours of services form. Indicate any changes from the original application.
- List which agencies and organizations are cooperating with the project and explain their role. **All** indicated agencies and organizations should have current MOUs with the project.
- Elaborate on special events and initiatives undertaken by the project in the Work Plan Activities listed on the Performance Measure Tables Work Plans.

III. Quality Assurance

1. Chart audit. If the Project served less than 200 clients, review 50 charts or all charts of clients served (whichever # is less annually). If the Project served 200 or more clients, review 100 charts. **Summarize the findings and indicate changes or improvements to be made.** The project should conduct 25% of the annual chart reviews during each quarter during the funding year and describe the reviews in the quarterly reports, along with adaptations, changes, or adjustments made in the work plan or policies and procedures as a result of the chart review findings.

2. Review the NS data reports. Summarize the data problems – incomplete collection or program challenges – indicating the specific areas. Review the charts to determine if staff completion or errors are contributing to the problem.

3. Report appropriate individuals to the IBDPR. Document every child with a birth defect that was seen in the Project clinic and verify that the child is reported to the Indiana Birth Defects and Problems Registry, provided the patient is within the appropriate age range.

4. Send a copy of the chart audit tool format used for each service type.

IV. Demographic Data

Complete Tables 1-4. This information is essential for Maternal and Child Health Services to meet federal reporting requirements.

Table 1. Number of New Individuals Who Received Services, Fiscal Year 2010, by Race

Class of individual and type of service	# Est. to be Served*	Race							Ethnicity		
		White	Black	American Indian	Asian or Pacific Islander	Multi-Racial	Other/ Unknown	Total Served (All Races)	Non-Hispanic/ Unknown	Hispanic	Total Served (All Ethnicity)
PREGNANT WOMEN											
INFANTS UNDER ONE YEAR OF AGE											
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)											
OTHER INDIVIDUALS											
OTHER INDIVIDUALS > 22 years											
OTHER SERVICES (SPECIFY):											
TOTAL (All Services):											

*As indicated in FY 2010/2011 proposal.
**If applicable

Totals Should Match

Table 2. Number of Return Visit Individuals Who Received Services, Fiscal Year 2010, by Race

Class of individual and type of service	# Est. to be Served*	Race							Ethnicity		
		White	Black	American Indian	Asian or Pacific Islander	Multi-Racial	Other/ Unknown	Total Served (All Races)	Non-Hispanic/ Unknown	Hispanic	Total Served (All Ethnicity)
PREGNANT WOMEN											
INFANTS UNDER ONE YEAR OF AGE											
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)											
OTHER INDIVIDUALS											
OTHER INDIVIDUALS > 22 years											
OTHER SERVICES (SPECIFY):											
TOTAL (All Services):											

*As indicated in FY 2010/2011 proposal.

Totals Should Match

Table 3. Number of New Individuals Who Received Services Provided or Paid for in Whole or in Part by NS or NS Matching Funds in Fiscal Year 2010, by Type of Health Coverage

Class of individual and type of service	Total	Hoosier Healthwise	Private Insurance	Self-Pay 25% - 100%	Unable to Pay
PREGNANT WOMEN					
INFANTS UNDER ONE YEAR OF AGE					
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)					
INDIVIDUALS AGE 22 AND OLDER					

Table 4. Number of Return Visit Individuals Who Received Services Provided or Paid for in Whole or in Part by NS or NS Matching Funds in Fiscal Year 2010, by Type of Health Coverage

Class of individual and type of service	Total	Hoosier Healthwise	Private Insurance	Self-Pay 25% - 100%	Unable to Pay
PREGNANT WOMEN					
INFANTS UNDER ONE YEAR OF AGE					
CHILDREN UNDER 22 (EXCLUDING THOSE UNDER ONE)					
INDIVIDUALS AGE 22 AND OLDER					

V. Program Monitoring Data

Tables 5 - 12 request program monitoring data.

Table 5: Types of Service Provided

Type of Service	Pregnant Women	Infants <1 Year of Age	Children Under 22 (Excluding Those < 1 yr)	Patients ≥ 22 years of age	Total
Pre-Diagnosis Counseling					
Post-Diagnosis Counseling					
Evaluation/Counseling for a **known** diagnosis					
Evaluation/Counseling for an **unknown** diagnosis					
Counseling Only					
Consultations					
Telephone Contacts					
Referrals To MCH Clinic					
Referrals To First Steps					
Referrals To NS					
Referrals To PSUPP					
Referrals To WIC Clinic					

See **Definitions** in Appendix 2 for clarification of the types of services.

Table 6: Educational Outreach Activities

	Number of Education Sessions Completed	Average Number of Participants per Session	Overall Score From Evaluation Sheets
Health care professionals and college or graduate level students			
General Public			
Other presentations			
TOTAL			

NOTE: The number of educational sessions should match the number given in the grant application. Additional information required in the Performance Measures section.

Table 7: Patient Satisfaction Surveys

	Number of Surveys Given to Clients	Number of Surveys Completed and Returned	Survey Return Rate	Score for Scheduling and Location	Score for Interaction with Clinic Staff	Score for Expectations and Understanding	Score for Benefits of Genetics Clinic	Score for Overall Satisfaction
Prenatal Services								
Clinical Services								
TOTAL								

Table 8: Primary Indication for Reason for Referral to Clinical Services

	FY 08	FY 09	FY 10
1. Rule Out/Confirm or Make Specific Diagnosis			
2. Return Visit (returning to same project group)			
3. Follow-up Appointment for Diagnosis Made by an Unaffiliated Provider			
4. Unknown Reason for Referral			
TOTAL			

Table 9: Final or Best Working Diagnosis for Clinical Patients

	FY 08	FY 09	FY 10
1. No Evidence of Abnormality or Specific Disorder			
2. Chromosomal and Single Gene Disorders			
3. Metabolic/Endocrine Disorder			
4. Neuromuscular			
5. Skeletal/Connective Tissue/Neural Ectodermal (Excluding Chromosomal)			
6. Hematologic			
7. Functional Disorders			
8. Single Malformation			
9. Reproductive Risks (Use only when none of the above apply)			
10. Multiple Congenital Anomalies/Multiple Malformation Syndrome			
11. Unknown			
TOTAL			

Note: See Appendix 3 for examples of ***Final or Best Working Diagnosis*** for each option.

Table 12: Unduplicated Patients Seen By County of Residence

COUNTY	PREGNANT WOMEN	CLINICAL PATIENTS	**TOTAL**
TOTAL			

VI. Project Data

Specific directions are stated for each Performance Measure. Indicate if the Performance Objective was met by checking Yes or No. A Performance Objective Summary of all services is provided in Appendix 1. Please complete the summary for all services provided by the project.

FY 2010 objectives should be completed based upon the projections submitted in the FY 2010 – 2011 grant application.

The specific activities for each objective should be completed and the status of each indicated in the Comments/Adjustments section. If objectives were not met, indicate in this column why they were not met and what action will be taken to meet them this year. Your consultant will use this section to monitor project activities and provide technical assistance. Some forms have specific activities already listed. The status of each should be indicated as well as any additional comments. Any additional activities for your project should be listed. (See Appendix 2 for additional instructions and definitions).

Sickle Cell Trait Follow-up Services Providers should complete the following pages addressing NS performance measures.

A. Sickle Cell Trait Follow-up Services

Performance Measure 1: Provide educational, counseling, and follow-up services to families of children originally referred by the Indiana Newborn Screening (NBS) laboratory with Sickle Cell trait or trait of another hemoglobinopathy.

Directions for Completion

Please complete the tables below. Report the total number of newborn patients originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy that received educational, counseling, and follow-up services. Only complete for patients in your project population.

Note: The ISDH Genomics and Newborn Screening Program expects at least **90%** of the families of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy to receive educational, counseling, and follow-up services.

Performance Objective 1a:

Ensure that at least ____% **(estimated goal)** of families of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy receive educational, counseling and follow-up services.

PO 1a: Educational, counseling, and follow-up services provided to families of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait for another hemoglobinopathy		
(b) Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait for another hemoglobinopathy whose families received the ISDH Sickle Cell Trait educational packet		
Percentage of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait for another hemoglobinopathy whose families received the ISDH Sickle Cell Trait educational packet.		
Estimated Goal (percentage) stated in the Grant Application		
Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait for another hemoglobinopathy whose families received direct counseling and/or follow-up services		

***Percentage = (b / a) x 100**

Performance Objective 1b:

Ensure that ____% **(estimated goal)** of primary care providers (PCPs) of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy receive the educational, counseling, and follow-up materials provided to their patients' families.

PO 1b: Contact with PCPs of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy that have a PCP		
(b) Total number of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy whose PCPs received the same educational, counseling, and follow-up materials that were provided to their patients' families		
Percentage of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or trait of another hemoglobinopathy whose PCPs received the same educational, counseling, and follow-up materials that were provided to their patients' families*		
Estimated Goal (percentage) stated in the Grant Application		

***Percentage = [(b / a) x 100]**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Supporting Activities Table

Directions: State the Activity Status and provide any Comments/Adjustments for the following activities. Additional measurable activities that aided in meeting this objective can be added at the bottom of this table.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments /Adjustments
Provide assistance in utilizing local resources to > 90% of patients/families of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or with trait of another hemoglobinopathy.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Provide > 90 % of PCPs of children originally referred by the Indiana NBS laboratory with Sickle Cell trait or with trait of another hemoglobinopathy with the same follow-up materials originally provided to the patient's family.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. Sickle Cell Trait Follow-up Services

Performance Measure 2: Provide educational, counseling, and follow-up services to families of children with Sickle Cell trait or trait of another hemoglobinopathy.

Directions for Completion

Please complete the table below. Report the total number of families that received educational, counseling, and/or follow-up services.

Note: The ISDH Genomics and Newborn Screening Program expects at least **95%** of families (whose children have Sickle Cell trait or trait of another hemoglobinopathy) who contact the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy will receive appropriate educational, counseling, and/or follow-up services.

Performance Objective 2:

Ensure that at least ____% **(estimated goal)** of families (whose children have Sickle Cell trait or trait of another hemoglobinopathy) who contact the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy receive educational, counseling, and/or follow-up services.

PO 2: Services provided to families (whose children have Sickle Cell trait or trait of another hemoglobinopathy) regarding Sickle Cell trait or trait of other hemoglobinopathies

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of children (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy		
(b) Total number of unduplicated children (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy who directly (face-to-face contact) received educational, counseling, and/or follow-up services		
(c) Total number of unduplicated children (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy who indirectly (phone call) received educational, counseling, and/or follow-up services		

Total number of children (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy who received the ISDH Sickle Cell Trait educational packet.		
Percentage of children (who have Sickle Cell trait or trait of another hemoglobinopathy) whose families contacted the grantee's center(s) seeking information regarding Sickle Cell trait or trait of another hemoglobinopathy who received either direct or indirect educational, counseling, and/or follow-up services*		
Estimated Goal (percentage) stated in the Grant Application		

***Percentage = [(b + c) / a)] x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Supporting Activities Table

Directions: State the Activity Status and provide any Comments/Adjustments for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Provide a hard copy of appropriate resource information to > 95% of families that contacted the grantee's center(s) seeking information.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Collect evaluation forms from parents. Use feedback from these evaluation sheets to modify and improve services.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. Sickle Cell Trait Follow-up Services

Performance Measure 3: Increase individual awareness and personal responsibility of health issues that impact the patient population and birth outcomes.

Directions for Completion

Please complete the tables below. The ISDH Genomics/NBS Program expects that at least **90%** of new families seen in person should be educated to the negative effects of smoking and consuming alcohol during pregnancy and the positive effects of taking folic acid.

Performance Objective 3a:
Ensure that _____% **(estimated goal)** of new families seen in person will be educated to the ***negative*** effects of ***smoking*** during pregnancy.

PO 3a: New families seen in person and educated to the *negative* effects of *smoking* during pregnancy

Annual Outcome Objective	**FY 2010**	**FY 2011**
(a) Total number of new families with members who smoke and were seen in person that received **smoking cessation education**		
(b) Total number of new families with members who reportedly smoke and were seen in person		
Percentage of new families with members who smoke and were seen in person that received **smoking cessation education***		
Estimated Goal (percentage) stated in the Grant Application		

*** Percentage = (a / b) x 100**

Performance Objective 3b:

Ensure that _____% **(estimated goal)** of new families seen in person will be educated to the ***negative*** effects of ***consuming alcohol*** during pregnancy.

PO 3b: New families who were seen in person and educated to the *negative* effects of *alcohol consumption* during pregnancy

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of new families who were seen in person and received education on **alcohol-related birth defects**		
(b)Total number of new families who were seen in person		
Percentage of new families who were seen in person and received education on **alcohol-related birth defects***		
Estimated Goal (percentage) stated in the Grant Application		

*** Percentage = (a / b) x 100**

Performance Objective 3c:

Ensure that _____% **(estimated goal)** of new families seen in person that will be educated to the ***positive*** effects of taking ***folic acid***.

PO 3c: New families seen in person and educated to the *positive* effects of taking *folic acid*

Annual Outcome Objective	FY 2010	FY 2011
(a) Total number of new families who were seen in person and received **folic acid education**		
(b) Total number of new families who were seen in person		
Percentage of new families who were seen in person and received **folic acid education***		
Estimated Goal (percentage) stated in the Grant Application		

*** Percentage = (a / b) x 100**

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Supporting Activities Table

Directions: State the Activity Status and provide any Comments/Adjustments for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Develop and incorporate an intake protocol asking patients if they took folic acid preconceptionally or smoked and/or consumed alcohol or other drugs during pregnancy.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Ensure that greater than 90% of individuals seen in person who admit to smoking, drinking, or using drugs are referred to appropriate community cessation programs (e.g. Prenatal Substance Use Prevention Program (PSUPP), Indiana Tobacco QuitLine, Alcoholics Anonymous).*			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

* Please see Sickle Cell Trait Follow-up Services Definitions on page 65 for contact information for available ISDH family support resources.

A. Sickle Cell Trait Follow-up Services

Performance Measure 4: Provide educational presentations to the general public.

Directions for Completion

Report the total number of presentations given by your project staff. A **minimum of 4** presentations are to be given to the general public. Calculate the Percent Completed only for the current year. In terms of estimating audience size, when the audience is mixed, count individuals under the group that makes up the majority of the audience. Do **not** count one talk under two different audiences; each presentation should be included in the column that corresponds to the majority of the audience.

Performance Objective 4: Project staff provided _____ presentations.

	# of Talks						
Main audience:	**FY 2009 Actual**	**FY 2010 Actual**	**FY 2010 Estimated**	***FY 2010 % Completed***	**FY 2011 Actual**	**FY 2011 Estimated**	***FY 2011 % Completed***
General Public							
Other presentations							
Total							

Percent completed = [Number of talks given / Estimated number of talks] x 100

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

Supporting Activities Table

Directions: State the Activity Status and provide any Comments/Adjustments for the following activities. Additional measurable activities that will assist in meeting this objective can be added at the bottom of this table.

Activity	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
Evaluation sheets will be collected for each talk; feedback from evaluation sheets will be used to modify and improve presentation.			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
Audience size will be counted at each talk. (**Note**: Attendance or evaluation sheets may be used to determine these numbers.)			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	
			☐ Initiated ☐ Ongoing ☐ Other ☐ Does not apply	

A. Sickle Cell Trait Follow-up Services

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

Type of Service	FY 2009	FY 2010	Percent change from previous year

Percent change = [(2010 #s – 2009 #s) / 2009 #s] x 100

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

A. Sickle Cell Trait Follow-up Services

PROJECT SPECIFIC PERFORMANCE MEASURE:

PERFORMANCE OBJECTIVE:

GOAL:

Type of Service	FY 2010	FY 2011	Percent change from previous year

Percent change = [(2011 #s – 2010 #s) / 2010 #s] x 100

PERFORMANCE OBJECTIVE MET: ☐ ***YES*** ☐ ***NO***

PROJECT SPECIFIC PERFORMANCE OBJECTIVE:

Work Plan Activities	Documentation Used	Staff Responsible	Activity Status	Comments/Adjustments
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	
			☐ Initiated ☐ Ongoing ☐ Completed ☐ Other	

Appendix 1

Sickle Cell Trait Follow-up Services Providers
Performance Objective Summary
FY 2010 & FY 2011

FY 2010

	MET	
PERFORMANCE OBJECTIVE 1a:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 1b:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 1c:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2a:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2b:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 2c:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 3:	☐ ***YES***	☐ ***NO***
PERFORMANCE OBJECTIVE 4:	☐ ***YES***	☐ ***NO***

Percent of NS Required Performance Objectives Met _____

Number of Project Chosen Objectives Met _____

Total Number of Project Chosen Objectives _____

Percent of Project Chosen Objectives Met _____

Appendix 2

Sickle Cell Trait Follow-up Services
DEFINITIONS
FY 2010 & FY 2011

Definitions are listed according to appearance in the application.

Tables 2 and 4

Return Visit Individuals – Individuals that have been previously seen in your project clinic and are returning for follow-up care.

Table 5

Clinical Patient – Any individual who had an appointment and was evaluated by or received counseling from the project.

Counseling Only – A communication which deals with the human problems associated with the occurrence or risk of occurrence of a disorder in a family. For reporting purposes, this **only** includes face-to-face interactions. No physical exam or prenatal procedure is performed during this type of encounter.

Consultation – A visit with a patient where the grantee is **not** the primary provider of services.

Telephone contact – A phone conversation where a limited amount of counseling and/or a referral is discussed.

Evaluation/Counseling – Some degree of assessment (e.g., a physical examination) is performed in addition to genetic counseling services.

Performance Measure 3 – Contact Information for ISDH Family Support Resources

- **Children's Special Health Care Services** (CSHCS)
  - 2 North Meridian Street, 7B, Indianapolis, IN 46204
  - (800) 475-1355 (phone)
    - Option 1 - Spanish Interpretation
    - Option 2 – Application Status or Eligibility/Reevaluation Information
    - Option 3 – Prior Authorization, Care Coordination or Insurance Updates
    - Option 4 – Travel Inquiries or Travel Reimbursement
    - Option 5 – Payment of Claims
    - Option 6 – Provider Relations & Provider Agreement

- **Indiana Family Helpline**
  - (800) 433-0746 (voice)
  - (866) 275-1274 (TTY / TDD)

- **Indiana Tobacco Quitline**
    - (800) QUIT-NOW
- **Prenatal Substance Use Prevention Program** (PSUPP)
    - PSUPP Director, Indiana State Department of Health
    - 2 North Meridian Street, Indianapolis, IN 46204
    - 317-233-1257 (phone)
    - 317-234-2995 (fax)
    - A list of PSUPP Program Clinics is available at http://www.in.gov/isdh/22245.htm.

Performance Measure 4

College or graduate level students – Includes nursing and medical students.

Appendix 3

Descriptions for Final or Best Working Diagnosis Table

(Five examples for each are listed.)

Chromosomal / Single gene
(includes cytogenetic and mutation analysis)
1) Trisomies
2) 45,X
3) 47,XXY
4) Fragile X
5) 22q11.2 deletion

Metabolic / Endocrine
1) PKU
2) Galactosemia
3) Hypothyroidism
4) Cystic Fibrosis
5) Tay-Sachs disease

Neuromuscular
1) Huntington disease
2) Muscular dystrophy
3) Mitochondrial disorders
4) Myasthenia gravis
5) Glycogen storage diseases

Skeletal / Connective Tissue
1) Marfan syndrome
2) Ehlers-Danlos syndrome
3) Tuberous sclerosis
4) Neurofibromatosis
5) Dysplasias

Hematologic
1) Hemophilia A
2) Other hemophilias
3) Alpha-thalassemia
4) Beta-thalassemia
5) Sickle cell anemia

Functional Disorders
1) Autism
2) Epilepsy
3) Cerebral palsy
4) Mental retardation
5) Failure to thrive / growth retardation

Single Malformation
1) Limb abnormalities
2) Anencephaly
3) Myelomeningocele
4) Cleft lip and/or palate
5) Heart defects

Reproductive Risk
1) Infertility
2) Consanguinity
3) Exposures
4) Known carrier
5) Increased empiric risk

Multiple Congenital Anomalies
1) CHARGE
2) VATER / VACTERL
3) MURCS
4) Pierre-Robin sequence
5) Potter sequence

Multiple Malformation
(More than one malformation is present and the overall gestalt does not match any known association or syndrome or sequence.)

NS DEFINITIONS
FY 2010 & FY 2011

Client/Patient – A recipient of services that are supported by program expenses funded in whole or in part by Children's Special Health Care Services (NS) or local (NS) matching dollars

Program Expenses – any expense included in the budget that the NS project proposes to be funded by NS or NS matching dollars (includes staff, supplies, space costs, etc.)

Matching Funds – At least 30% of the NS award. Whatever dollars the project assigns to support the NS funded service (includes Medicaid or other income generated by service provision).

Types of Clients – Pregnant women, infants, children, adolescents, adult women and families

NS Supported Services

- Direct medical and dental care: Family Planning, Prenatal Care, Child Health (infant, child adolescent), Women's Health
- Enabling services: Prenatal Care Coordination, Family Care Coordination

These definitions will allow NS projects to include all clients seen that are funded by NS or NS match dollars in their client count. They will also allow projects to enroll all clients that are served by staff paid with NS or NS matching funds.

Cultural Competence

Cultural competence requires that organizations:

- Have a defined set of values and principles and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally;
- Have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of the communities they serve;
- Incorporate the above in all aspects of policy making, administration, practice, and service delivery and involve systematically consumers, key stakeholders and communities.

Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (adapted from Cross et al., 1989)

INDIANA STATE DEPARTMENT OF HEALTH
MATERNAL AND CHILD HEALTH SERVICES
GRANT APPLICATION SCORING TOOL

FY 2010 & FY 2011 NS Application Review Score: _____

Applicant Agency: _____
Project Title: _____
Reviewer: _____
Date of Review _____

Content Assessment

1.0 Applicant Information – Form A is complete (3 points)

Includes ***all*** of the following elements

____ Title of Project
____ Federal I.D. #
____ Medicaid Provider #
____ FY 2009 NS contract amount
____ Funds requested, matching funds contributed FY 2010 & FY 2011
____ Complete sponsoring agency data
____ Project Director signature
____ Authorized legal signature
____ County Health Officer signature
____ Secretary of State registration

NOTE: Primary and Secondary Reviewers do not need to evaluate section 1.0. Business Management staff will evaluate this section.

1.0 Score:_____
(3 points maximum)

2.0 Table of Contents

Table indicates the pages where each Section begins including appendices. □ Yes □ No

NOTE: Primary and Secondary Reviewers do not need to evaluate section 2.0. Business Management staff will evaluate this section.

***This document is an adaptation of an instrument by Dr. Wendell F. McBurney, Dean, Research and Sponsored Programs, Indiana University-Purdue University at Indianapolis. Dr. McBurney has granted permission of use of this adaptation.**

3.0 NS Proposal Narrative (15 points)

3.1 Project Summary includes ***all*** of the following elements (3.1 = 10 points max.)

____ Relates to NS services only
____ Addresses project's capacity to add these services
____ Describes how the project will provide these services
____ Justifies the need for funding

3.2 Form B **(5 points)** (3.2 = 5 points maximum)

- NS Project Description (B-1)

____ Brief history is included
____ Problems to be addressed are identified
____ Objectives and workplan are summarized

- Clinic Site information (B-2)

____ Project locations are identified
____ Target population and numbers to be served by site are identified
____ NS and Non-NS budget information per site is included

Comments:

3.0 Score:_____
(30 points maximum)

4.0 Applicant Agency Description

Flows from general to specific and includes ***all*** of the following elements:

4.1 Description of sponsoring agency

____ Mission statement
____ Brief history
____ Description of administrative structure (organization chart is included)
____ Project locations

4.2 Discussion of proposer's role in community and local collaboration (MOUs and MOAs attached if not previously submitted)

Comments:

4.0 Score:_____
(5 points maximum)

5.0 Tables

____ NS service forms and tables are completed for one or more of the proposed services.
- ____ Pregnant women
- ____ Child health
- ____ Family planning
- ____ School-based adolescent health
- ____ Family care coordination
- ____ Women's health

____ Performance objectives are included
____ Appropriate activities are included
____ Appropriate measures, documentation, and staff responsible for measuring activities are included
____ Project identifies how ISDH priority health initiatives will be incorporated into service delivery (activities on PM tables)

NOTE: Projects do not need to apply for every service (or even more than one) to receive full points for this section. Evaluators should verify that the application contains all required Performance Measure Tables for each service proposed and evaluate the quality of those tables.

Comments:

6.0 Score:_____
(15 points maximum)

6.0 Evaluation Plan Narrative

____ Project-specific objectives are measurable and related to improving health outcomes
____ Plan explains how evaluation methods reflected on the Performance Measures tables will be incorporated into the project evaluation
____ Staff responsible for the evaluation is identified
____ What data will be collected and how it will be collected are identified
____ How and to whom data will be reported are identified
____ Appropriate methods are used to determine whether measurable activities and objectives are on target for being met
____ If activities and objectives are identified as not on-target during an intermediate or year-end evaluation and improvement is necessary to meet goals, who is responsible for revisiting activities to make changes which may lead to improved outcomes
____ Methods used to evaluate quality assurance (e.g. chart audits, client surveys, presentation evaluations, observation) are described
____ Methods used to address identified quality assurance problems

Comments:

7.0 Score:_____
(10 points maximum)

8.0 Staff

____ Staff is qualified to operate proposed program
____ Staffing is adequate
____ Job description and curriculum vitae of key staff are included as an appendix

Comments:

8.0 Score:_____
(4 points maximum)

7.0 Facilities

____ Facilities are adequate to house the proposed program
____ Facilities are accessible for individuals with disabilities
____ Facilities will be smoke-free at all times
____ Hours of operation are posted and visible from outside the facility

Comments:

9.0 Score:_____
(4 points maximum)

9.0 Budget and Budget Narrative

____ Relationship between budget and project objectives is clear
____ All expenses are directly related to project
____ Time commitment to project is identified for major staff categories and is adequate to accomplish project objectives

Comments:

10.0 Score:_____
(18 points maximum)

9.1 Budget and Budget Narrative Forms

____ Budget pages 1, 2, and 3 are complete for each year
____ Budget narratives include justification for each line item and are completed for each year
____ Budget correlates with project duration
____ Funding received from ISDH (Form C) is complete
____ Information on each budget form is consistent with information on all other budget forms

NOTE: Primary and Secondary Reviewers do not need to evaluate section 10.1. Business Management staff will evaluate this section.

10.1 Score:_____
(4 points maximum)

10.0 Minority Participation

____ Statement regarding minority participation in program design and evaluation

Comments:

11.0 Score:_____
(2 points maximum)

11.0 Endorsements

____ Endorsements are from organizations able to effectively coordinate programs and services with applicant agency
____ Memoranda of Understanding (MOU) clearly delineate the roles and responsibilities of the involved parties in the delivery of community-based health care
____ Endorsements and/or MOUs are current
____ Endorsement or MOU with Local Public Health Coordinator
____ Letters and a summary of the proposed program have been sent to all health officers in jurisdictions within the proposed service area (unless health officer(s) has signed Form A)

Comments:

11.0 Score:_____
(5 points maximum)

TOTAL SCORE (To be calculated by Business Management staff):_____
(100 points maximum)

CHECKLIST **To be completed by Business Management Staff**

The following forms are completed:

Application Information – **Form A** □ Yes □ No

NS Project Description – **Form B** (B-1, B-2) □ Yes □ No

Funding Received thru ISDH – **Form C** □ Yes □ No

Informing Local Health Officers of Proposed Submission

- Includes letters to all health officers in jurisdictions included in proposed service area(s) or signature(s) of health officer(s) on Form A □ Yes □ No

Project Performance During FY 2008 & FY 2009

The Regional Health Systems Development Consultant (primary reviewer) should describe below performance achievements and/or problems/concerns identified in review of the FY 2008 & FY 2009 Annual Performance Reports that are relevant to this proposal.

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